CERTIFICATE OF INSURANCE

TO: INDIANA PATIENT'S COMPENSATION FUND
MEDICAL MALPRACTICE DIVISION
311 W. WASHINGTON ST. STE.300
INDIANAPOLIS, IN 46204-2787

		Surcharge	Effective Date
Cancellation:	☐	$_____	_____
Return/Additional Surcharge		$_____	_____
Credit		_____%	_____

Policy No.:	Occurrence Claims Made Reporting Endors.	☐ ☐ ☐	Retro Date _____ Retro Date _____
Health Care Provider: Medical License No.:	Including employees ☐		Excluding employees ☐
Address (Street, City, State, Zip):	County:		
Coverage Dates: From: _____ To: _____	Classification Number:		
Limits of Liability $_____ per occurrence $_____annual aggregate	Premium Amount: Surcharge Amount: Penalty Amount:		

The undersigned Insurance Company, hereby certifies limits of liability on behalf of the above referenced Health Care Provider of not less than Two Hundred and Fifty Thousand ($250,000) Dollars for each occurrence and with an annual aggregate of Seven Hundred and Fifty Thousand ($750,000) Dollars as required, unless otherwise mandated by statute, for claims against said Health Care Provider as a result of Medical Malpractice, or allegation thereof, within the State of Indiana, and further that said policy of insurance complies in all respects with the provisions of the Indiana Patient's Compensation Act Indiana Code 34-18-1-1 et seq.

It is further certified that the surcharge for the above referenced coverage for the period specified in this policy is at the appropriate Class rate for the named specialty, is based upon the published calculation for a hospital, or is One Hundred Percent (100%) of the premium for non-physician or non-hospital providers. Said Company also agrees to collect and remit the rated surcharge or a minimum surcharge of one hundred ($100.00) dollars, whichever is larger, for each year of the period of coverage to the Department of Insurance, Patient's Compensation Fund, State of Indiana, within **thirty (30) days and not more than ninety (90) days from the effective date of said policy.**

It is further acknowledged that in the event of termination of the policy herein certified, or any reduction of liability limit, such termination or change shall not be effective unless notice of same has been delivered to the Department of Insurance, State of Indiana, not less than thirty (30) days prior to such change. Notice shall be considered to have been given upon placing same in the United States Mail by First Class Certified Mail, a copy of which shall have been mailed to the health care provider.

Dated this ____ day of _____, 20___ at the insurance office of _____

Signed by: _____
Authorized Signature
Printed: _____
Title: _____

Pac-3/State Form 2713R5
Revised 7/18/03